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6

7 BEFORE THE
BOARD OF PODIATRIC MEDICINE
8 DIVISION OF ALLIED HEALTH PROFESSIONS
MEDICAL BOARD OF CALIFORNIA
9 DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA
10

11 In the Matter of the Accusation)	No. D-4204
Against:)	
12 WILLIAM MEDITZ, D.P.M)	ACCUSATION
13 1235 Vista Way)	
14 Vista, California 92083)	
15 License No. E2262)	
16 Respondent.)	

17 COMES NOW, Complainant, James H. Rathlesberger,
18 Executive Officer, Board of Podiatric Medicine, who alleges:

19 1. He is the Executive Officer for the Board of
20 Podiatric Medicine and files this accusation in his official
21 capacity.

22 LICENSE STATUS

23 2. On or about June 19, 1978, William J. Meditz,
24 D.P.M., (respondent) was issued license No. E-2262 authorizing
25 him to practice podiatric medicine in the State of California.
26 There is no record of prior discipline.

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STATUTES

3. Business and Professions Code section 2222 (all code references are to the Business and Professions Code unless otherwise indicated) provides that the Board of Podiatric Medicine (Board) shall enforce the provisions of the Medical Practice Act as to all holders of a podiatry certificate.

4. Code section 2234 provides, in part, the Board shall take action against any licensee who is guilty of:

"(b) Gross negligence.

"(c) Repeated negligent acts.

"(d) Incompetence."

CHARGES AND ALLEGATIONS OF UNPROFESSIONAL CONDUCT

Patient - Alice V.

5. Alice V., was a 73 year-old female, who became a patient of respondent on or about August 15, 1988. According to respondent's progress notes for Alice V., her chief complaint concerned a painful bump on the dorsum of her right foot and a hammertoe of the left 2nd digit. Respondent discussed alternative treatment methods with Alice V. but recommended surgery.

6. Respondent performed surgery on Alice V. on August 22, 1988. He performed an implant arthroplasty second Extensor Z-plasty. Respondent did not prepare an operative report for this procedure.

7. On August 29, 1988, respondent received back a report on the culture and sensitivity test performed August 25, 1988. The results showed that Alice V. had an infection of 1

1 enterobacter Cloacae abundant growth and coagulase negative
2 staphylococci abundant growth. The organisms were both sensitive
3 to Ciprofloxacin. The prescriptions of Ciproflfoxacin given to
4 Alice V. were subclinical.

5 8. On September 1, 1988, respondent changed
6 antibiotics because the patient complained of headaches. He
7 placed Alice V. on tetracycline 500 even though the culture and
8 sensitivity tests showed that the staph coag negative is
9 resistant to tetracycline.

10 9. On September 25, 1988, a single AP radiograph
11 revealed that the implant was out of position and medially
12 displaced.

13 10. On October 13, 1988, Alice V. returned to
14 respondent's office. Additional radiographs revealed a
15 dislocation and rotation of the implant with changes consistent
16 with osteomyelitis in the 2nd metatarsal and proximal phalangeal
17 base as well as questionable changes in the 4th proximal
18 phalangeal base.

19 11. Alice V. left the care of respondent and was seen
20 by an orthopedic surgeon who diagnosed her condition as
21 osteomyelitis with foreign body right foot. Whereupon, the
22 patient underwent hospitalization and treatment including
23 incision and drainage for removal of the silastic cap and
24 debridement of the osteomyelitis area. The patient was continued
25 on intravenous antibiotics for 6 weeks. She was then released
26 from the hospital and placed on antibiotics.

27 12. Respondent is guilty of gross negligence (2234

(b)) and incompetence (2234 (d)) by reason of, but not limited to the following:

A. Respondent performed the elective surgery described above in spite of the fact the patient had an ongoing infection in her body (bladder) for which she was taking Amoxicillin.

B. Respondent failed to perform an adequate initial physical examination, in that, among other things, he failed to perform a complete vascular exam and did not do any neurological, dermatological or biomechanical evaluations. In addition no differential diagnosis was established.

C. Respondent failed to prepare an operative report of the surgery performed on August 22, 1988.

D. Respondent failed to perform adequate and necessary pre-operative laboratory tests.

E. No peri-operative antibiotics either intravenous or oral was given.

F. The use of Ciprofloxacin to control infection was subclinical.

G. On the patients post-operative visit of September 7, 1988, the wound should have been recultured because of the presence of a deep hematoma that needed to be drained.

H. Many of respondent's records are not legible.

I. Following the visit by the patient on October 13, 1988, with the evidence of osteomyelitis, respondent should have referred Alice V. to a specialist in infectious disease or to an orthopedic surgeon for hospitalization.

As a result of the aforementioned, respondent is

1 subject to discipline.

2 Patient-Jessica O. (a minor).

3 13. Jessica O. was a 12 year-old female who became a
4 patient of respondent on May 6, 1987. Jessica's chief complaint
5 concerned a bunion on her right foot with sharp shooting pain off
6 and on for two months.

7 14. On or about May 15, 1987, respondent performed the
8 following surgical procedure on Jessica O.: Base wedge
9 metatarsal bunionectomy right foot and phalangeal osteotomy right
10 foot. On the May 29, 1987, post-operative office visit,
11 respondent prescribed the antibiotic, Duracef. On June 8, 1987,
12 Duracef was again prescribed. Respondent did not note in the
13 patient's chart the efficacy of the prior prescription of
14 Duracef.

15 15. On or about November 23, 1987, respondent
16 performed a base wedge bunionectomy with internal fixation and
17 wedge osteotomy proximal phalanx left foot. There was no
18 physical examination performed on the patient prior to the
19 surgery.

20 16. On or about May 10, 1988, Jessica O. returned to
21 respondent's office with a complaint of pain in the left
22 metatarsal phalangeal joint after a horse stepped on her foot.
23 According to respondent his radiographs revealed a chip fracture.

24 17. On or about September 14, 1988, Jessica returned
25 to respondent's office. Respondent performed a range of motion
26 test that caused pain to Jessica. Respondent reported that the
27 single AP radiograph showed the chip impinged in the metatarsal

1 phalangeal joint and he recommended surgery.

2 18. On or about October 6, 1988, respondent performed
3 the surgical removal of bone on the first metatarsal left foot.
4 The surgery was performed without the patient being properly
5 anesthetized causing the patient extreme pain throughout the
6 procedure. In addition, the patient's mother and grandmother
7 were permitted in the room in street clothes and without proper
8 gowning. No operative report was prepared by respondent.

9 19. On October 10, 1988, Jessica returned to
10 respondent's office complaining of extreme pain. A culture and
11 sensitivity was obtained. The lab report of October 12, 1988,
12 showed that the patient had an infection of klebsiella oxytoca
13 and organism staphylococcus aureas.

14 20. The patient returned on October 13, 1988, with a
15 temperature of 99.2. The patient's mother also telephoned
16 respondent on that date to complain that her daughter had
17 swelling and pain. On October 15, 1988, Jessica again returned
18 to respondent's office. Her temperature was 97.2 and there was a
19 hematoma present. The infection was getting worse.

20 21. The patient returned on October 17, 1988. Her
21 temperature was 97.8. A radiograph taken by respondent suggested
22 osteomyelitis.

23 22. Jessica left the care of respondent and was
24 treated by other physicians who diagnosed osteomyelitis of the
25 left great toe. She was hospitalized on October 20, 1988, and
26 discharged October 29, 1988 at which time her progress was
27 followed by an infectious disease consultant.

23. Respondent's is guilty of gross negligence (2234 (b)) and incompetence (2234 (d)) in his management and treatment of Jessica O. by reason of, but not limited to, the following:

A. Because of the patient's history of scarlet fever, respondent should have, but failed to provide antibiotic prophylaxis at the time of surgery.

B. When respondent place Jessica on antibiotics following surgery, he continually failed to note the medical indications for the use of the antibiotic, failed to note the dosage, failed to note the strength prescribed and the duration.

C. Respondent failed to prepare operative reports for the surgical procedures perform on November 23, 1987, and October 6, 1988.

D. During the surgery of October 6, 1988, respondent permitted a non-sterile operative area to be created by allowing ungowned persons into the operative room.

E. Respondent failed to manage and treat the patient's infections by not obtaining appropriate consultations and/or failing to hospitalize her. Respondent also failed to aggressively treat the infections by not using intravenous antibiotics.

F. Respondent did not perform any physical exam of the patient prior to the surgeries of November 23, 1987, and October 6, 1988.

G. Respondent performed the surgery on Jessica on October 6, 1988, without providing sufficient and proper anesthesia as a result the patient suffered extreme and great

1 pain during the surgery.

2 As a result, respondent is subject to discipline.

3 24. As a result of respondent's repeated failure to
4 prepare operative reports on patients Alice V. and Jessica O. as
5 described above, he is guilty of repeated acts of negligence in
6 violation of 2234 (c) and subject to discipline.

7 25. Respondent's overall management and treatment of
8 the infections of patients Alice V. and Jessica O. described
9 above is evidence of and constitutes incompetence in violation of
10 2234 (d). As a result, respondent is subject to discipline.

11 WHEREFORE, complainant requests that a hearing be held
12 on the matters alleged herein, and that following said hearing,
13 the Board issue a decision.

14 1. Revoking or suspending License Number E2262,
15 heretofore issued to respondent William Meditz, D.P.M.;

16 2. Taking such other and further action as the Board
17 deems appropriate to protect the public health, safety and
18 welfare.

19 DATED: March 20, 1990

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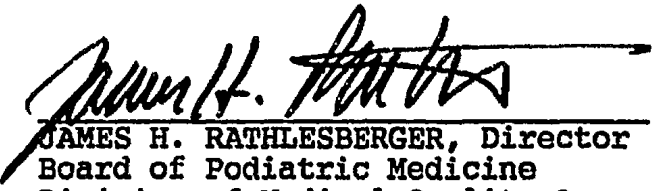
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JAMES H. RATHLESBERGER, Director
Board of Podiatric Medicine
Division of Medical Quality Assurance
Department of Consumer Affairs
State of California

Complainant

BDL:sg